Arizona Criminal Justice Commission

Crime Victim Compensation Program

APPLICATION

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Arizona Criminal Justice Commission
Crime Victim Compensation Program

ELIGIBILITY REQUIREMENTS

Have you been an innocent victim of crime that caused physical harm or extreme mental distress? Are you an Arizona resident who has been a victim of international terrorism?

.....if the answer is yes, you *MAY* be eligible for financial compensation for out-of-pocket crime-related expenses.

GENERAL CRITERIA FOR ELIGIBILITY

- The victim is victimized in Arizona or is an Arizona resident who is a victim of international terrorism.
- The crime is reported to a police agency within 72 hours of the discovery of the crime unless good cause is shown to justify a delay.
- An application is filed within 2 years of the discovery of the crime in the county in which the crime occurred unless good cause is shown to justify a delay.
- The victim or derivative victim willingly cooperates with law enforcement agencies.
- The victim or a derivative victim suffers physical injury or extreme mental distress as a direct result of the criminally injurious conduct.
- The victim or derivative victim incurs economic loss as a direct result of the crime which is not covered by a benefit or advantage that the person is entitled to receive from a collateral source.

Submitting an application for compensation does NOT guarantee an award. Awards are based on eligibility and funding availability. FUNDS ARE VERY LIMITED.

VICTIM COMPENSATION MAY PAY FOR:

Crime related:

- Medical costs
- Funerals – up to $5,000
- Counseling – up to 36 months
- Work loss – Minimum wage – Sick leave & vacation leave must be utilized first.

The maximum award of any one claim is $20,000. Awards are based on eligibility and funding availability. FUNDS ARE VERY LIMITED.

VICTIM COMPENSATION *CANNOT* PAY FOR:

- Crime scene clean up
- Property loss or repair
- Pain and suffering
- Attorney fees
- Copying fees
- Victimization of a person serving a sentence of imprisonment in a detention facility, home arrest, or work furlough, or who has escaped imprisonment in a detention facility, home arrest, or work furlough program.

FOR MORE INFORMATION, CONTACT THE PHONE NUMBERS BELOW:

The Crime Victim Compensation Board is administered through the County Attorney's Offices in each of Arizona's fifteen counties. Awards for crime victims are determined by the Crime Victim Compensation Boards. Innocent victims of crime may apply for eligible compensation in the county where the crime occurred.

For further information, please call the Crime Victim Compensation Program in the county where the crime occurred. Phone numbers are listed below:

Apache County Attorney's Office
(928) 337-7560

Cochise County Attorney's Office
(520) 432-8731

Victim/Witness Services for
Coconino County (928) 527-0708

Gila County Attorney's Office
(928) 425-4120

Graham County Attorney's Office
(928) 428-4787

Greenlee County Attorney's Office
(928) 865-4108

La Paz County Attorney's Office
(928) 669-6118

Maricopa County Attorney's Office
(602) 506-4955

Mohave County Attorney's Office
(928) 718-5522

Navajo County Attorney's Office
(928) 524-4332

Pima County Attorney's Office
(520) 740-5525

Pinal County Attorney's Office
(520) 866-6271

Santa Cruz Co Attorney's Office
(520) 281-5868

Yavapai County Attorney's Office
(928) 771-3485

Yuma County Attorney's Office
(928) 329-2133

AZ Criminal Justice Commission
Crime Victim Compensation Program

Application

Medical___ Funeral/Burial___
Loss of Wages___ M/H Counseling___

Please return to:

Date Received:_____ Staff Assigned:_____ Case Number:_____

PART 1: VICTIM INFORMATION - *Please complete the application as thoroughly as possible and SIGN the application on pages 6 and 7.*

Victim's Last Name	First Name	Middle Name
Address (Street)		Sex: ☐ Male ☐ Female
City / State	County	Zip Code
Date of Birth	Home Phone ( )	Work Phone ( )
Social Security Number (If available)		Is victim deceased? ☐ Yes ☐ No

PART 2: CLAIMANT INFORMATION *(Complete ONLY if different from victim)*

Claimant's Last Name	First Name	Middle Name
Address (Street)		Sex: ☐ Male ☐ Female
City / State	County	Zip Code
Date of Birth	Home Phone ( )	Work Phone ( )
Social Security Number (If available)		
Your Relationship to the Victim		

Please List The Following Information For Each Victim/Derivative Victim *(Attach additional sheets if necessary)*

Victim/Derivative's Name	Social Security Number (If available)	Date Of Birth	Relationship To Victim
1.			
2.			
3.			

PART 3: CRIME INFORMATION

Type of Crime (*check one*)		**Was this crime DOMESTIC VIOLENCE related?**
☐ Assault	☐ Stalking	☐ Yes ☐ No
☐ Homicide	☐ Robbery	
☐ Sexual Assault/Adults Only	☐ Terrorism	
☐ Child Abuse (Physical & Sexual)	☐ Kidnapping	
☐ DWI/DUI	☐ Other Crimes (List)_____	

Date of Crime	Date Crime Reported	Law Enforcement Agency Reported To

Name of Officer/Detective	Report Number

Location of Crime	Offender(s) Name

Briefly Describe Crime and Injuries (Attach additional sheets if necessary)

PART 4: CIVIL LAWSUIT INFORMATION

Have you or will you file a civil lawsuit (sue) in relation to this crime? ☐ Yes ☐ No ☐ Undecided
If yes, please list the name and address of your attorney:

Attorney's Name	Phone Number ( )

Street Address	City	State	Zip Code

PART 5: BENEFIT INFORMATION

Since the crime have you received or are you entitled to receive any of the following benefits listed below. For each benefit checked, please supply requested information on Lines 1 through Line 4 below. (Attach additional sheets if necessary)

AHCCCS	☐	Health/Accident Insurance	☐	Social Security (SSD)/(SSI)	☐
Auto Insurance	☐	Indian Health Services	☐	Tribal Assistance	☐
Tricare/Military	☐	Life Insurance	☐	Veteran's Benefits	☐
Child Protective Service	☐	Medical Insurance	☐	Vision Insurance	☐
Dental Insurance	☐	Medicare/Medicaid	☐	Workers Compensation	☐
Disability Insurance	☐	Restitution (from offender)	☐	Other:_____	
Employee Assistance	☐	Sick Leave/Vacation	☐		

Are any of these benefits pending (*please specify*)_____

For each benefit checked, please supply requested information on Lines 1 through Line 4 below. *(Attach additional sheets if necessary)*

Type Of Benefit	Address	Phone	Agency/Policy Number
1.		( )	
2.		( )	
3.		( )	
4.		( )	

PART 6: TYPE OF COMPENSATION REQUESTED

A. MEDICAL

Are you seeking payment for medical, hospital, or traditional healing expenses that are crime related? ☐ Yes ☐ No

Name Of Provider	Address	Account Number	Phone	Date Of Service
1.			( )	
2.			( )	
3.			( )	
4.			( )	
5.			( )	
6.			( )	

B. MENTAL HEALTH COUNSELING:

Are you seeking payment for mental health treatment expenses that are crime related? ☐ Yes ☐ No

If **YES,** are you currently seeing a provider? ☐ Yes ☐ No

If **YES,** are you claiming mileage for crime related mental health counseling?

Name Of Provider	Address	Account Number	Phone	Date of Service
1.			( )	
2.			( )	
3.			( )	

MILEAGE: Are you claiming mileage for crime related medical or mental health counseling? ☐ Yes ☐ No

If **YES**, please list the dates of trips and the mileage traveled round trip:

Date of trip_____ Mileage traveled round trip_____

Date of trip_____ Mileage traveled round trip_____

Date of trip_____ Mileage traveled round trip_____

Date of trip_____ Mileage traveled round trip_____

C. WORK/SUPPORT LOSS: (All sick leave and vacation leave available must be utilized first – wage loss is calculated at the minimum wage rate)

Are you seeking work loss benefits as a result of the injury or mental distress? ☐ Yes ☐ No

If **YES,** please answer the questions listed below:

Date first unable to work as a result of injury or mental distress:_____

Date returned to work:_____

Total time lost from work:_____

Hourly rate of pay:_____Number of hours worked per week:_____Hours worked per day:_____

Place of Employment Supervisor's Name

Address City State Zip Code Phone

( )

REQUIREMENT: A signed statement on office letterhead stationery from the employer will be required to verify the above work loss information. A signed statement on office letterhead stationery from the doctor or mental health therapist is also required stating that the victim was unable to work as a result of crime related injuries, the length of time the victim was unable to work and the date the victim was able to (or will be able to) return to work.

D. FUNERAL EXPENSES:
Are you seeking payment for crime related funeral expenses? ☐ Yes ☐ No

Name of Funeral Service Provider:	Amount $

Address	City	State	Zip Code	Phone ( )

REQUIREMENT: If you answered YES to Part 6A, 6B, 6C, or 6D, please attach a copy of <u>ALL bills, contracts, receipts and insurance statements received to date.</u>

PART 7: STATISTICAL INFORMATION (If available)

The following information is used for statistical purposes only. It is needed to comply with federal regulations. Information applies to the VICTIM only.

Ethnic Group: ☐ Caucasian ☐ Hispanic ☐ Unknown
☐ African American ☐ Native American/Eskimo ☐ Other_____
☐ Asian/Pacific Islander

Arizona Resident: ☐ Yes ☐ No Federal Crime: ☐ Yes ☐ No
Handicapped: ☐ Yes ☐ No

I learned about the Crime Victim Compensation Program from:

☐ Victim Assistance Program ☐ Prosecutor ☐ Medical Service Provider ☐ Self Referral
☐ Law Enforcement Agency ☐ Brochures/ Posters, etc. ☐ Social Service Agency ☐ Other

DEFINITIONS:

VICTIM

"Victim" means a person who suffers physical injury, extreme mental distress, or death as a direct result of any of the following:

a. Criminally injurious conduct;
b. An act of international terrorism;
c. A person's good faith effort to prevent criminally injurious conduct; or
d. A person's good faith effort to apprehend a person suspected of engaging in criminally injurious conduct or an act of international terrorism

DERIVATIVE VICTIM

"Derivative victim" means:

a. The spouse, child, parent, stepparent, stepchild, sibling, or guardian of a victim who died as a result of criminally injurious conduct or act of international terrorism and includes a child born after the victim's death.
b. A person living in the household of a victim who died as a result of criminally injurious conduct.
c. A member of the victim's family who witnessed the criminally injurious conduct.
d. A non-family member who witnessed a violent crime.
e. A person whose mental health counseling and care or presence during the victim's mental health counseling and care is required for the successful treatment of the victim.

CLAIMANT

"Claimant" means any natural person filing a claim under these rules and authorized to receive a compensation award for economic loss because the person is:

a. A victim of criminally injurious;
b. A resident of this state who is injured by an act of international terrorism;
c. A derivative victim;
d. A person authorized to act on a victim's behalf, or a person authorized to act on behalf of a deceased victim's dependent if the victim died as a direct result of criminally injurious conduct or an act of international terrorism; or
e. A person who assumes an obligation or pays an expense directly related to a victim's economic loss incurred as a direct result of criminally injurious conduct or an act of international terrorism.

PLEASE TURN TO THE FOLLOWING PAGES AND SIGN THE APPLICATION IN ALL FOUR SECTIONS.

You Must Sign In Four (4) Places Or Your Application Can Not Be Processed.

Carefully read and sign the declarations below and on the following page (pg. 7). Your application will not be processed unless this form is completed and signed on each of the FOUR (4) signature lines.

Declaration

I hereby certify, subject to the penalty of fine or imprisonment, that the information contained in this application for a crime victim compensation award is true and correct to the best of my knowledge.

Certification of Eligibility

I certify that all of the information provided on this form by me and/or others is true and accurate to the best of my knowledge and belief.

I certify that I am not currently serving a sentence of imprisonment in any detention facility, and had not escaped from serving a sentence of imprisonment in any detention facility, home arrest program or work furlough at the time of the criminally injurious conduct.

I certify that I will fully cooperate with all appropriate law enforcement, prosecutorial and criminal justice agencies and provide the information requested understanding that if I do not cooperate any and all benefits may be denied.

_____ _____ **X**_____

Date **Please Print Name** **Signature of Claimant/Applicant**

Arizona Criminal Justice Commission
Subrogation Agreement

Agreement made this____ day of _____, 20____, between the Claimant, _____
(Claimant's Name)
and the State of Arizona by the Arizona Criminal Justice Commission

Crime Victim Compensation Program of _____ County.

In consideration of monies to be paid to me or paid to others for my benefit in accordance with the Crime Victim Compensation Program Rules as an award through the Crime Victim Compensation Program, I, _____, hereby assign, transfer and subrogate to the State of Arizona the first right to the full extent of any monies paid as stated above, and also to the _____ County Crime Victim Compensation Program to the extent that the monies advanced were obtained from sources other than the Arizona Criminal Justice Commission, all rights which I may have to receive, or recover any benefits or advantages which I may have against any party for claim, loss, damage, or injuries suffered for which an award was made.

_____ _____ **X**_____

Date **Please Print Name** **Signature of Claimant/Applicant**

Authorization to Release Confidential Information

I authorize and request any person or agency having information, including any law enforcement records, which are necessary to the administration of my claim to release that information to the _____ County Crime Victim Compensation Program. This release includes, but is not limited to, local, state, and federal law enforcement and prosecutors offices; local, state, and federal court personnel; any employer, any private company or governmental agency which is providing, or may provide, monetary benefits.

I authorize my attorney to provide any information for this purpose of verifying my claim and eligibility for crime victim compensation and to provide information concerning any potential recovery which I may have against any person or entity arising from the criminally injurious conduct. I understand that the records obtained by the _____ County Crime Victim Compensation Program may be subject to release in accordance with Arizona and federal law.

I agree and certify that no person or agency shall incur any legal liability to me by releasing any information pursuant to this authorization.

_____ _____ **X**_____

Date **Please Print Name** **Signature of Claimant/Applicant or Representative/Guardian of Applicant**

If this Authorization is signed by someone other than the Claimant/Applicant, please state your authority to sign on behalf of the Claimant/Applicant: _____

Authorization for Use or Disclosure of Protected Health Information

I authorize my medical provider or mental health practitioner to release of medical, dental, and psychotherapy records relating to the incident that occurred on or about _____ to the _____ County Crime Victim Compensation Program for the purpose of verifying my claim and eligibility for Crime Victim Compensation. This release includes, but is not limited to, private and government physicians and hospitals, and any private company or governmental agency which is providing, or may provide, medical benefits.

This is a general authorization and includes authorization for the release of confidential communicable disease related information and confidential HIV related information.

I may revoke this Authorization at any time. My revocation must be in writing and signed by me. My revocation will be effective upon receipt, but it will not be effective if and to the extent that the Crime Victim Compensation Program or others have already acted in reliance upon this Authorization. Upon revocation of this Authorization, I will become ineligible to receive benefits from the Crime Victim Compensation Program.

I understand that there is a potential for unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules. Information disclosed to the Crime Victim Compensation Program is no longer subject to the protections of HIPPA. The Crime Victim Compensation Program may disclose non-identifying information for statistical purposes.

I understand that I may refuse to sign this Authorization. My refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits, except that my refusal to sign this Authorization will make me ineligible to receive benefits from the Crime Victim Compensation Program.

This Authorization expires twelve months from the date of signature.

_____	_____	**X**_____
Date	**Please Print Name**	**Signature of Claimant/Applicant or Representative/Guardian of Applicant**

If this Authorization is signed by someone other than the Claimant/Applicant, please state your authority to sign on behalf of the Claimant/Applicant: _____